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Attorneys for Complainant

BEFORE THE DEPARTMENT OF MANAGED HEALTH CARE

OF THE STATE OF CALIFORNIA

IN THE MATTER OF:	Enforcement Matter No.: 05-268
Vision Plan of America	OAH No.: L2006070515
Respondent.	**ORDER ADOPTING PROPOSED DECISION**

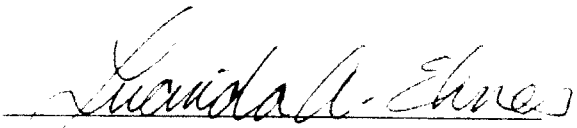
DECISION

Pursuant to Government Code section 11517(c)(2)(A), the Department of Managed Health Care adopts, in its entirety, the attached Proposed Decision dated September 6, 2006, issued by Administrative Law Judge H. Stuart Waxman, OAH – Los Angeles, in the above-entitled matter.

It is so Ordered.

DEPARTMENT OF MANAGED HEALTH CARE

Dated: October 30, 2006



LUCINDA EHNES
Director
California Department of Managed Health Care

BEFORE THE
DEPARTMENT OF MANAGED HEALTH CARE
OF THE STATE OF CALIFORNIA

IN THE MATTER OF:	**Case No. 05-268**
Vision Plan of America	**OAH No. L2006070515**
Respondent.	

PROPOSED DECISION

This matter came on regularly for hearing before H. Stuart Waxman, Administrative Law Judge, Office of Administrative Hearings, at Los Angeles, California on August 23, 2006.

Amy L. Dobberteen (Complainant) was represented by Thomas P. Meyer, Senior Counsel, California Department of Managed Health Care.

Vision Plan of America (Respondent) was represented by its President, Dr. Stuart W. Needleman (Dr. Needleman).

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision.

FACTUAL FINDINGS

The Administrative Law Judge makes the following Factual Findings:

1. The Accusation was made by Complainant, who is the Assistant Deputy Director of the California Department of Managed Health Care (Department), Office of Enforcement, acting in her official capacity.

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2. At all relevant times, Respondent was, and still is, a licensed specialized health care service plan, as defined by Health and Safety Code section 1345, subdivision (f). Its principal office is located in Los Angeles, California. Respondent holds health care service plan license number 933-0268, issued on January 30, 1987. Pursuant to that license, Respondent is subject to the provisions of the Knox-Keene Health Care Service Plan Act of 1975 (Health and Safety Code, Chapter 2.2, section 1348, subdivision (c) et seq.), as amended.

3. Health and Safety Code[1] section 1348, subdivision (a) requires every health care service plan to submit to the Department an antifraud plan. Subdivision (c) of that statute requires all health care service plans to submit to the Department annual written reports "describing the plan's efforts to deter, detect, and investigate fraud, and to report cases of fraud to a law enforcement agency." At all relevant times, the annual antifraud reports were to be submitted to the Department by January 31 of each year, and were to address pertinent information regarding the prior calendar year.

4. On December 9, 2002, the Department sent a letter to Respondent informing Respondent of the requirement that its antifraud report be filed by January 31, 2003.

5. On February 10, 2003, the Department sent an e-mail to all licensed health care service plans, including Respondent, in which it clarified the requirements referenced in Code section 1348.

6. Respondent's 2003 antifraud report was due on January 31, 2004. Respondent failed to submit its report by the deadline.

7. On June 22, 2004, the Department wrote to Respondent advising that the antifraud report had not been received, and advising Respondent that an Accusation could be filed against it. Through that Accusation, the Department would seek an administrative penalty.

8. Respondent filed its 2003 antifraud report on August 16, 2004, almost seven months late. The Department did not file an Accusation in connection with the 2003 antifraud report at that time.

9. Respondent's 2004 antifraud report was due on January 31, 2005. Respondent failed to submit that report by the deadline.

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[1] All statutory references are to the Health and Safety Code unless otherwise indicated.

10. On September 20, 2005, the Department wrote to Respondent advising that the antifraud report had not been received. The final paragraph of that letter read:

> This [antifraud] report is to be filed immediately, or in five (5) business days. Pursuant to Health and Safety Code section 1386, the Department will file an Accusation seeking to impose an administrative penalty of $5,000.00 as a result of the Plan's violation of Health and Safety Code section 1348(c). Prior to serving and filing the Accusation, the Department provides a health care service plan with the opportunity to submit any documentation or other evidence that it believes establishes that it has not operated in violation of the Knox-Keene Health Care Service Plan Act of 1975, as amended, in this matter. Your written response should be submitted no later than ten (10) business days from the date of this letter. . . .

11. Respondent submitted its 2004 antifraud report on September 23, 2005, almost eight months after the mandatory deadline. It did not provide any evidence in response to the Department's September 20, 2005 letter.

12. On October 19, 2005, the Department again wrote to Respondent advising that it intended to file an Accusation and seek a $5,000 administrative penalty for Respondent's failure to timely file its 2004 antifraud report. On October 20, 2005, Respondent wrote to the Department. The letter read, in pertinent part:

> While Vision Plan of America understands the importance of each filing to the Department, the plan inadvertently provided the Department with a late filing of the Antifraud Annual Report.
>
> The Plan has an antifraud policy which it takes very seriously and monitors carefully through its utilization system, provider audits and reviews in its quality assurance program and has its independent fraud contractor at the Plan level monitoring all functions. There is not fraud nor has there been any fraud detected at the enrollee level, provider level or Plan level.
>
> The Plan understands that a penalty will be assessed, however, I am appealing to the Department at this time for a lesser penalty as the Plan is in dire straits and is reduced at this point in time to no new revenues as the Department's web site still shows a Cease and Desist Order against the Plan.

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13. On November 30, 2005, the Department issued a written response to Respondent's October 20, 2005 letter. The Department's letter stated in relevant part:

> This letter is in response to your letter dated October 20, 2005 requesting a reduction in the assessed penalty of five thousand dollars ($5,000.00) for Vision Plan of America's (the "Plan") failure to submit its 2003 and 2004 antifraud annual reports to the Department of Managed Health Care (the "Department") in a timely manner. In this letter, you stated that the Plan is in dire straits and is reduced at this point in time to no new revenues as the Department's website still shows a Cease and Desist Order against the Plan. The Plan reports cash as $177,180, Total Current Assets as $238,354, and Total Current Liabilities as $132,887. Based on the financial status reported by the Plan as of September 30, 2005, there is no justification for mitigating the penalty amount.
>
> Therefore, the Department intends to file an accusation seeking to impose an administrative penalty of five thousand dollars ($5,000.00.) [*sic*] . . .

14. At the hearing, Dr. Needleman did not claim that Respondent was in "dire straits" financially, but did argue that larger companies than Respondent had occasionally incurred smaller fines, even for medical issues. He also claimed that Respondent's failure to timely file the two antifraud reports had been an oversight by an employee who was no longer with the company. Those arguments are not well taken. Respondent offered no evidence of similarities or differences between the facts in this case and those involving larger companies and/or smaller administrative penalties. Therefore, no comparison of assessed administrative penalties can be made to determine the reasonableness of the penalty sought by the Department in this case. Further, although an employee's inadvertence may have been the cause of the late filings, Respondent is nonetheless held to the filing deadline. Were this outcome otherwise, no point would exist in establishing a filing deadline since any employee error would excuse a plan's tardiness in filing its antifraud reports. However, the Department may have taken the inadvertence of Respondent's employee into account in determining to impose an administrative penalty in this case instead of seeking license suspension or revocation.

15. Dr. Needleman also claimed that no pattern of non-compliance had been established. He was incorrect. In two consecutive years, Respondent was approximately seven months late and eight months late, respectively, in filing its antifraud reports despite written reminders from the Department. The Department clearly established a pattern of non-compliance by Respondent regarding the timely reporting requirement for antifraud reports.

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16. Finally, Dr. Needleman argued that a "fair and reasonable" standard should be employed in this case. While that standard is not inherently improper, it must apply equally to both parties. There is nothing unfair or unreasonable in imposing a deadline for a specialized health care service plan to file its antifraud report, and there is nothing unfair or unreasonable in selecting January 31 of each year as that deadline. What is unreasonable, however, is missing the filing deadline by approximately seven months in one year, and by approximately eight months the following year.

LEGAL CONCLUSIONS

Pursuant to the foregoing Factual Findings, the Administrative Law Judge makes the following legal conclusions:

1. Cause exists to impose an administrative penalty against Respondent, pursuant to Health and Safety Code sections 1386, subdivision (a) and 1386, subdivision (b)(6), for failure to timely file two antifraud reports, required pursuant to Health and Safety Code section 1348, subdivision (c), as set forth in Findings 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15 and 16.

2. Code section 1348 states in relevant part:

> (a) Every health care service plan licensed to do business in this state shall establish an antifraud plan. The purpose of the antifraud plan shall be to organize and implement an antifraud strategy to identify and reduce costs to the plans, providers, subscribers, enrollees, and others caused by fraudulent activities, and to protect consumers in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud. The antifraud plan elements shall include, but not be limited to, all of the following: the designation of, or a contract with, individuals with specific investigative expertise in the management of fraud investigations; training of plan personnel and contractors concerning the detection of health care fraud; the plan's procedure for managing incidents of suspected fraud; and the internal procedure for referring suspected fraud to the appropriate government agency.
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> [¶] . . . [¶]

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(c) Every health care service plan that establishes an antifraud plan pursuant to subdivision (a) shall provide to the director an annual written report describing the plan's efforts to deter, detect, and investigate fraud, and to report cases of fraud to a law enforcement agency. For those cases that are reported to law enforcement agencies by the plan, this report shall include the number of cases prosecuted to the extent known by the plan. This report may also include recommendations by the plan to improve efforts to combat health care fraud.

3. Code section 1386 states in pertinent part:

(a) The director may, after appropriate notice and opportunity for a hearing, by order suspend or revoke any license issued under this chapter to a health care service plan or assess administrative penalties if the director determines that the licensee has committed any of the acts or omissions constituting grounds for disciplinary action.

(b) The following acts or omissions constitute grounds for disciplinary action by the director:

[¶] . . . [¶]

(6) The plan has violated or attempted to violate, or conspired to violate, directly or indirectly, or assisted in or abetted a violation or conspiracy to violate any provision of this chapter, any rule or regulation adopted by the director pursuant to this chapter, or any order issued by the director pursuant to this chapter.

4. Despite several reminders and warnings by the Department, Respondent failed to timely file its antifraud reports for two consecutive years. In both years, substantial amounts of time lapsed before Respondent filed the reports. Whether those lapses occurred by inadvertence or intent, cause exists to impose an administrative penalty.

5. The $5,000 administrative penalty the Department seeks to impose is deemed just and reasonable. Respondent is financially able to pay that sum, and the imposition of the penalty will not result in an unreasonable onus on Respondent.

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ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Within 30 days of the effective date of this decision, Respondent, Vision Plan of America, shall pay to the Department an administrative penalty of $5,000.

DATED: September 6, 2006

H. STUART WAXMAN
Administrative Law Judge
Office of Administrative Hearings